[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]
Subject: Appeal for Denied Medical Claim - [Claim Number]
Dear [Claims Adjuster's Name],
I am writing to formally appeal the denial of my medical claim (Claim Number: [Claim Number]) for [specific treatment/procedure] that took place on [date of service]. The claim was denied on [denial date], citing [reason for denial].
I believe this claim should be approved based on [provide your reasons, such as medical necessity, supporting evidence, doctor's recommendation, etc.]. Enclosed are copies of supporting documents, including [list documents, e.g., medical records, bills, letters from healthcare providers].
Thank you for your attention to this matter. I look forward to your prompt response to my appeal.
Sincerely,
[Your Name]
[Your Policy Number]